House of Representatives

General Assembly

File No. 304

February Session, 2014

Substitute House Bill No. 5451

House of Representatives, April 2, 2014

The Committee on Labor and Public Employees reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE POOLING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2014*) (a) Not later than October 1, 2015, and annually thereafter, each municipality that sponsors a group health policy or plan for its active employees, early retirees and retirees that provides coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes shall submit electronically to the State Comptroller, in a form prescribed by the Comptroller, the following information for the policy or plan year immediately preceding:

(1) A list of each type of group health policy or plan offered to the municipality's employees, early retirees and retirees and specific details for each such policy or plan, including, but not limited to:

(A) Covered benefits and any limits on such benefits;

(B) (i) The total premium costs or if applicable premium equivalent costs for each policy or plan, organized by coverage tier, including, but not limited to, single, two-person and family including dependents for active employees, early retirees and retirees, and (ii) the employee share, the early retiree share and the retiree share of each such total premium cost;

(C) Employee, early retiree and retiree cost-sharing requirements such as coinsurance, copayments, deductibles and other out-of-pocket expenses associated with in-network and out-of-network providers; and

(D) If a municipality sponsors a prescription drug plan, the value of any rebates or cost reductions provided to such municipality for such plan;

(2) A list of the total number of employees, early retirees and retirees in each policy or plan, organized by (A) municipal department, (B) collective bargaining unit, if applicable, (C) coverage tier, including, but not limited to, single, two-person and family including dependents, and (D) active employee, early retiree or retiree status; and

(3) For the two policy or plan years immediately preceding, the percentage increase or decrease in the policy or plan costs, calculated as the total premium costs, inclusive of any premiums or contributions paid by active employees, early retirees and retirees, divided by the total number of active employees, early retirees and retirees covered by such policy or plan.

(b) No municipality submitting information pursuant to subsection (a) of this section shall include health information in such information.

Sec. 2. Section 38a-513f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(a) As used in this section:

(1) "Claims paid" means the amounts paid for the covered employees of an employer by an insurer, health care center, hospital service corporation, medical service corporation or other entity as specified in subsection (b) of this section for medical services and supplies and for prescriptions filled, but does not include expenses for stop-loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features, administrative costs or profit.

(2) "Employer" means any town, city, borough, school district, taxing district or fire district employing more than fifty employees.

(3) "Utilization data" means (A) the aggregate number of procedures or services performed for the covered employees of the employer, by practice type and by service category, or (B) the aggregate number of prescriptions filled for the covered employees of the employer, by prescription drug name.

(b) (1) Each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall:

[(1)**]** (A) Not later than October first, annually, provide to an employer sponsoring such policy, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, ending not more than sixty days prior to the date of the request, in a format as set forth in **[**subdivision (3)**]** subparagraph (C) of this **[**subsection**]** subdivision:

[(A)**]** (i) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

[(B)**]** (ii) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-network providers, and the total number of claims paid;

[(C)**]** (iii) Premiums paid by such employer by month; and

[(D)**]** (iv) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

[(2)**]** (B) Include in such information specified in **[**subdivision (1)**]** subparagraph (A) of this **[**subsection**]** subdivision only health information that has had identifiers removed, as set forth in 45 CFR 164.514, is not individually identifiable, as defined in 45 CFR 160.103, and is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, or regulations adopted thereunder; and

[(3)**]** (C) Provide such information **[**(A)**]** (i) in a written report, **[**(B)**]** (ii) through an electronic file transmitted by secure electronic mail or a file transfer protocol site, or **[**(C)**]** (iii) through a secure web site or web site portal that is accessible by such employer.

[(c)**]** (2) Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall not be required to provide such information to the employer more than once in any twelve-month period.

[(d) (1)**]** (3) (A) Except as provided in **[**subdivision (2)**]** subparagraph (B) of this **[**subsection**]** subdivision, information provided to an employer pursuant to **[**subsection (b) of this section**]** subdivision (1) of this subsection shall be used by such employer only for the purposes of obtaining competitive quotes for group health insurance or to promote wellness initiatives for the employees of such employer.

[(2)**]** (B) Any employer may provide to the Comptroller upon request the information disclosed to such employer pursuant to subsection (b) of this section. The Comptroller shall maintain as confidential any such information.

[(e)**]** (4) Any information provided to an employer in accordance

with [subsection (b) of this section] subdivision (1) of this subsection or to the Comptroller in accordance with [subdivision (2)] subparagraph (B) of [subsection (d)] subdivision (3) of this [section] subsection shall not be subject to disclosure under section 1-210. An employee organization, as defined in section 7-467, that is the exclusive bargaining representative of the employees of such employer shall be entitled to receive claim information from such employer in order to fulfill its duties to bargain collectively pursuant to section 7-469.

[(f)] (c) If a subpoena or other similar demand related to information provided pursuant to subsection (b) of this section is issued in connection with a judicial proceeding to an employer that receives such information, such employer shall immediately notify the insurer, health care center, hospital service corporation, medical service corporation or other entity that provided such information to such employer of such subpoena or demand. Such insurer, health care center, hospital service corporation, medical service corporation or other entity shall have standing to file an application or motion with the court of competent jurisdiction to quash or modify such subpoena. Upon the filing of such application or motion by such insurer, health care center, hospital service corporation, medical service corporation or other entity, the subpoena or similar demand shall be stayed without penalty to the parties, pending a hearing on such application or motion and until the court enters an order sustaining, quashing or modifying such subpoena or demand.

(d) (1) Not later than October 1, 2014, and annually thereafter, each insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, amending or continuing in this state any group health insurance policy sponsored by an employer and providing either administrative services only or providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 shall submit to the Comptroller the information set forth in subparagraphs (A)(i) and (A)(ii) of subdivision (1) of subsection (b) of this section for the policy year immediately preceding for each such

employer.

(2) Such information shall be submitted electronically to the Comptroller, in a form prescribed by the Comptroller, regardless of whether an employer requests such information pursuant to subparagraph (A) of subdivision (1) of subsection (b) of this section. Disclosure of any such information to the Comptroller pursuant to this subsection shall be made in compliance with subparagraph (B) of subdivision (1) of subsection (b) of this section.

(3) The Comptroller shall maintain any information disclosed in accordance with this subsection as confidential and such information shall not be subject to disclosure under section 1-210.

(e) Not later than January 1, 2016, and annually thereafter, the Comptroller shall submit a report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, insurance, labor and planning and development, that provides estimated costs or savings for each employer or municipality for which information was submitted pursuant to subsection (d) of this section and section 1 of this act if such employer was to obtain health benefits coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 from the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259.

Sec. 3. (*Effective July 1, 2014*) (a) With respect to the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, on and after July 1, 2014, and until June 30, 2015:

(1) The office of the State Comptroller shall have the authority to convene a working group, including, but not limited to, (A) to the extent applicable, health insurance companies, health care centers, hospital service corporations, medical service corporations or other entities delivering, issuing for delivery, renewing, amending or continuing such plans, (B) third-party administrators providing

administrative services only for such plans pursuant to subdivision (2) of subsection (m) of section 5-259 of the general statutes, (C) health care providers, (D) health care facilities, (E) the Office of Policy and Management, and (F) state employees and retirees, to facilitate the development and establishment of health care provider payment reforms for the group hospitalization and medical and surgical insurance plans established under subsection (a) of section 5-259 of the general statutes, including, but not limited to, multipayer initiatives, patient-centered medical homes, primary care case management, value-based purchasing and bundled purchasing. Any participation by such entities and individuals shall be on a voluntary basis.

(2) (A) The Comptroller, or the Comptroller's designee, may (i) conduct a survey of the entities and individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this subsection, concerning payment delivery reforms, and (ii) convene meetings of the working group at a time and place that is convenient for the entities and individuals specified in subparagraphs (A) to (F), inclusive, of subdivision (i) of this subsection.

(B) The Comptroller, or the Comptroller's designee, shall ensure that no such survey or working group participants shall solicit, share or discuss pricing information.

(C) (i) Any survey conducted pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or subject to disclosure under section 1-210 of the general statutes.

(ii) Any meeting convened pursuant to subparagraph (A) of this subdivision shall not be a violation of chapter 624 of the general statutes or constitute a meeting for the purposes of chapter 14 of the general statutes.

(3) (A) If the Comptroller determines that entering a cooperative agreement with any of the entities or individuals specified in subparagraphs (A) to (D), inclusive, of subdivision (1) of this

subsection will likely produce efficiencies and improvements in health care outcomes, the Comptroller may enter into one or more such agreements to (i) identify and reward high quality, low-cost health care providers, (ii) create enrollee incentives to receive care from such providers, and (iii) create enrollee incentives to promote personal health behaviors that will prevent or effectively manage chronic diseases, including, but not limited to, tobacco cessation, weight control and physical activity.

(B) The Comptroller may establish guidelines for such cooperative agreements. Any such agreement shall be consistent with federal antitrust laws and regulations promulgated by the Federal Trade Commission and chapter 624 of the general statutes.

(b) Not later than January 1, 2016, the Comptroller shall submit a report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, labor and public health on the recommendations of any working group convened by the Comptroller pursuant to subsection (a) of this section. Such report shall include, but not be limited to, (1) (A) any cost containment measures, and (B) descriptions of any quality measurement or quality improvement initiatives implemented as a result of the recommendations of such working group, and (2) any cost savings or health outcome improvements associated with such measures or initiatives.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2014*	New section
Sec. 2	*July 1, 2014*	38a-513f
Sec. 3	*July 1, 2014*	New section

LAB *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 $	FY 16 $
Comptroller	GF - Cost	Up to $735,000	Up to $745,575
State Comptroller - Fringe Benefits[1]	GF - Cost	$86,010	$90,027

Municipal Impact: None

Explanation

The bill may result in a cost to the Office of the State Comptroller (OSC) of up to $735,000 in FY 15 and $745,575 in FY 16 to prepare the annual report assessing the cost or savings to municipal employers for joining the Partnership Plan for health insurance and to administer the provisions of the bill ($500,000 annually for actuarial services, $235,000 in FY 15 and $245,575 in FY 16 for personal services). In addition, the OSC- fringe benefit accounts will incur a cost of $86,010 in FY 15 and $90,027 in FY 16 for fringe benefits for two additional staff members.

The bill's provisions are not anticipated to result in a cost to municipal employers. Fully insured municipalities through their insurance carrier, and self-insured municipalities through their third party administrator, have access to claims data, member information, and plan documents.

The bill's provisions granting authority to the OSC to convene a working group and enter into cooperative agreements do not result in

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 36.66% of payroll in FY 15 and FY 16.

a fiscal impact to the OSC or the state employee and retiree health plan. Cooperative agreements will facilitate the OSC's ability to implement patient-centered medical homes and other outcome driven programs for the state health plan. Lastly, the OSC is already engaged in the evaluation of payment reform and initiatives to improve patient outcomes with the State Innovation Model (SIM).

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis
sHB 5451

AN ACT CONCERNING HEALTH CARE POOLING.

SUMMARY:

This bill requires entities that issue or administer group health insurance policies for certain municipal employers, by October 1, 2014, and municipalities that sponsor these policies for their employees or retirees, by October 1, 2015, to begin annually submitting specific policy and claims-related information to the state comptroller. The information must cover policies providing (1) basic hospital or medical-surgical expense coverage, (2) major medical expense coverage, (3) hospital or medical service plan contracts, (4) hospital and medical coverage for health care center subscribers, and (5) single service ancillary health coverage.

The bill requires the comptroller to use this information to prepare an annual report that estimates the costs or savings available to the reporting municipal employers if they obtained group health insurance under the plan available to state employees (i.e., the Connecticut Partnership Plan). The comptroller must submit the reports to the Appropriations, Insurance and Real Estate, Labor and Public Employees, and Planning and Development committees, with the first report due by January 1, 2016.

The bill also allows the comptroller to (1) convene a temporary working group to develop health care provider payment reforms for the group health insurance plans offered to state employees and (2) enter into a cooperative agreement with certain group health insurers, administrators, and health care providers if he determines it will likely produce efficiencies and improve health care outcomes. The comptroller must report on the group's recommendations by January

1, 2016.

EFFECTIVE DATE: July 1, 2014

MUNICIPAL INSURERS' REPORT

By October 1, 2014, and annually thereafter, the bill requires certain entities to submit to the comptroller, for each covered municipal employer, the previous policy year's (1) complete medical, dental, and pharmaceutical utilization data, as applicable, and (2) annual claims paid, aggregated by practice type and service category, and reported separately for in- and out-of network providers and total number of claims paid. Covered municipal employers are municipalities and school, taxing, or fire districts, with at least 50 employees.

The reporting requirement applies to each insurer, health care center, hospital service corporation, medical service corporation, or other entity (1) delivering, issuing for delivery, renewing, amending, or continuing a covered employer's group health insurance policy and (2) providing either (a) only administrative services or (b) one of the specified types of coverage.

By law, policy issuers must provide this and other information to municipal employers upon request and the employer can provide it confidentially to the comptroller. The bill requires the reporting entities to submit this information electronically to the comptroller in a form prescribed by the comptroller, regardless of whether a covered municipal employer asked for the information. The disclosed information (1) can include only health information with identifiers removed, as required by federal regulations; (2) cannot be individually identifiable, as defined in federal regulations; and (3) must be allowed under the federal Health Insurance Portability and Accountability Act (HIPAA). The comptroller must maintain the disclosed information as confidential and it is not subject to disclosure under the state's Freedom of Information Act.

MUNICIPAL REPORT

By October 1, 2015, and annually thereafter, the bill requires

municipalities that sponsor group health policies or plans that provide the types of coverage specified above for their active employees or retirees to submit information to the comptroller. The required information, which must be submitted electronically in a form prescribed by the comptroller, is:

1. a list of each of the municipality's offered group health policies or plans and their specific details including (a) covered benefits and benefit limits, (b) total premium costs or premium equivalent costs for each policy or plan, organized by coverage tier, including single, two-person, and family, including dependents, and (c) the employee, early retiree, or retiree share for each total premium cost;

2. cost-sharing requirements, such as coinsurance, copayments, deductibles, and other out-of-pocket expenses associated with in-network and out-of-network providers;

3. the value of any prescription drug plan rebates or cost reductions;

4. the total number of employees, early retirees, and retirees in each policy or plan, organized by (a) municipal department, (b) collective bargaining unit, if applicable, (c) coverage tier, and (d) active employee, early retiree, or retiree status; and

5. the percentage change in per-person policy or plan costs over the preceding two policy or plan years.

The bill prohibits municipalities submitting this information from including health information in it.

COMPTROLLER'S WORKING GROUP

The bill allows the comptroller to convene a temporary working group, from July 1, 2014 to June 30, 2015, to develop and establish health care provider payment reforms for the group health insurance plans offered to state employees. The reforms can include multi-payer

initiatives, patient-centered medical homes, primary care case management, value-based purchasing, and bundled purchasing.

The comptroller cannot require any parties to participate in the group, which can include:

1. health insurance companies, health care centers, hospital service corporations, medical service corporations, or other entities delivering, issuing for delivery, renewing, amending, or continuing group health insurance plans;
2. third-party administrators providing only administrative services for the state's self-insured plans;
3. health care providers;
4. health care facilities;
5. the Office of Policy and Management; and
6. state employees and retirees.

Working Group Survey and Meetings

The bill allows the comptroller, or his designee, to (1) survey the non-governmental entities eligible to participate in the working group about payment delivery reforms and (2) convene work group meetings at a time and place convenient to all of the participants. The comptroller, or his designee, must ensure that the survey and working group participants do not solicit, share, or discuss pricing information.

The bill specifies that the survey and working group meetings are not (1) violations of the state's Anti-Trust Act or (2) subject the state Freedom of Information Act's disclosure or notice requirements.

Cooperative Agreements

The bill allows the comptroller to enter into cooperative agreements with any of the non-governmental entities eligible to participate in the working group if he determines that it will likely produce efficiencies

and improvements in health care outcomes. The agreements can be to (1) identify and reward high-quality, low-cost health care providers or (2) create incentives for enrollees to (a) receive care from such providers or (b) promote personal health behaviors that prevent or effectively manage chronic diseases, including tobacco cessation, weight control, and physical activity.

The comptroller can establish guidelines for these agreements, which must be consistent with federal and state antitrust laws and the Federal Trade Commission's regulations.

Report

By January 1, 2016, the comptroller must report to the Appropriations, Labor, and Public Health committees on the working group's recommendations. The report must include (1) any cost containment measures, (2) descriptions of any quality measurement or quality improvement initiatives implemented on the working group's recommendation, and (3) any cost savings or health outcome improvements associated with these measures or initiatives.

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable Substitute
Yea 7 Nay 3 (03/18/2014)